RECORDS RETENTION SCHEDULE

Commission for Children with Special Health Care Needs

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STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Commission for Children with Special Health Care Needs
Administrative Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
04316	Transmittal of Title XVI Referral to Designated State Agency - (SSI Referral) Closed Date: 6/13/2008 (C) KRS 200.490 Change Date: 9/9/1993	Close series. This series documented referral transmittals of children who did not meet the eligibility requirements to participate in certain disabled programs available for children. The key factor in these referrals was that the children must be under three years of age. The transmittals received with children's names that were over three are automatically considered ineligible. The agency communicated with the Social Security Administration and the Division of Disability Determination, Cabinet for Human Resources, to discontinue sending the referrals of children older than three. Referrals received for children who were eligible will become a part of the Client's Chart (03195).	Series contains: medical history; reports of medical and psychological evaluations; parent/guardian's name and address; client's local district Social Security office; information regarding disability status; date disability began/ceased; Disability Determination decisions	Agency: 6 months Destroy	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Administrative Services

Personnel

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03196	Position Control Report - (Duplicate) (MRR) Closed Date: 6/13/2008	Closed series. This series documented positions for employment which had been established and authorized for use by the Commission. It was used as an information and resource document for easy and quick reference to data regarding occupied and vacant positions. It was generated by the Personnel Management Information and Operations Section on a weekly basis.	Series contains: position numbers; class codes; class titles; pay grades; work counties; pending position and personnel actions; employee names; social security numbers; status of positions; salaries of incumbents; increment dates; sex and race of incumbents; summary of total positions established; total active employees; total employees on leave	Agency: I Retain in agency no longer than one year	Records Center:	Archives Center:
03197	Increment List - (Duplicate) (MRR) Closed Date: 6/13/2008	Closed series. This series documented a listing of employees who were eligible for either an annual increment, initial probationary increment and/or a promotional increase in salary. It was checked against employees who are eligible for salary increases each month. The series was generated by the Personnel Management Information and Operations Section of the Health Services Cabinet.	Series contains: listing of names of employees; social security numbers; class titles and codes; pay grades; salaries; status of employees; type of increments	Agency: 1 Destroy	Records Center:	Archives Center:
03198	Time Audit, Report 3 - (Duplicate) (MRR) Closed Date: 6/13/2008	Closed series. This series documented an examination of the actual time worked and leave time used by employees of the Commission. It functioned as an information document to verify if charges have been made to the correct program or function codes. It was generated by each pay period by the Office of Administrative Services, in the Cabinet.	Series contains: listing of employees with a breakdown of leave time utilized - annual leave, sick leave, compensatory leave, holidays, other paid leave with the cost for each category; time worked by each employee by program/function codes with the cost for each; individual totals for leave used and each program/function code	Agency: 2 Destroy	Records Center:	Archives Center:
03199	Time Audit, Report 8 - (Duplicate) (MRR) Closed Date: 6/13/2008	Closed series. This series documented an examination of the listing by cost center of payroll expenses for employees of the Commission. It provided information for other state and federal reports. The series was generated by the Office of Administrative Services, in the Health Services Cabinet.	Series contains: itemized listing of the cost of salaries; leave time used; employer's share of FICA taxes; employer's share of retirement; amount paid by the state for health and life insurance; totals for each employee and cost center	Agency: 2 Destroy	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Commission for Children with Special Health Care Needs
Administrative Services
Provider Relations Branch

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03204	Patients Statement of Account	This series documents the charges of a patient that has accumulated services rendered from clinics, hospitals or insurance charges filed on their behalf. The Patient's Statement of Account is mailed to the patient's home address as identified in the Computer Utilization Program (CUP). Payments are processed at the Commission for Children with Special Health Care Needs. Copies of the check or money order are kept on file with the Commission for Children with Special Health Needs and the hard copy filed is only used to verify deposits and payments.	Series may contain: Patient name; address; patient identification number; statement closing date; name and address of the Commission for Children with Special Health Care Needs; amount paid; dates of charges; description of services; previous balance; amount; current amount due; 30 days; 60 days; 90 days; 120 days or over; statement closing date; total amount due	Agency: 5 Destroy after audit	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Administrative Services

Reimbursement

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03200	Total Practice Management System - (TPMS - financial software package, accounting module) (V) (Electronic) Closed Date: 6/13/2008 (C) KRS 200.490 (V)	Closed series. This series provided financial and historical family data for purposes of billings and collections, third party billings, insurance billing, accounts receivable control, appointments, patient encounters, and interfaces. There are communication capabilities between the Administrative Building and the Clinical Services Building. Information was updated as accounts change (payments received). It was backed up once or twice a day and kept 1) on-site 2) in a safe, and 3) off-site in the Clinical Services Building. The Commission planned to expand these operations to their 12 district offices, and to interface with the local health department's patient encounter system.	Series contains: appointment reporting menu; accounts receivable reporting menu; practice management reporting menu; patient activity reporting menu; static reporting menu (See attachment for reports produced)	Agency: I	Records Center:	Archives Center:
				Update as changes occur. Daily backup procedures will apply		
03201	Health Insurance Claim Form Closed Date: 6/13/2008	Closed series. This series documented a form which recorded changes on patients' accounts by an insurance claim. It was used for all insurance billing purposes and allows the Reimbursement Section to file insurance claims with companies throughout the commonwealth. A patient that receives treatment from a hospital or clinic would receive a bill for those services. The section completed the claim form to forward to the insurance company. Bills were entered daily. Payment to the treatment centers was processed through the agency and was entered on the account.	Series contains: patient's name; address; date of birth; sex; insurer's identification number; patient's relationship to insurer; insurer's name; group number; other health insurance coverage; address of insurer; signature; physician or supplier information; diagnosis; date and place of service; medical services; diagnosis code; charges; days; signature of physician; patient's account number; employer identification number; total charge; amount paid; balance due; physician's name; address; phone number	Agency: 5	Records Center:	Archives Center:
				Destroy after audit		

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03202	Medical Assistance Statement - Medical Closed Date: 6/13/2008	Closed series. This series documented the cost of services provided by general medical aid such as hospitalization, pharmacy services, renal dialysis services, podiatry services, vision services, hearing services, mental health services, and home health services, among others. The agency was reimbursed the difference between the amount that would be deducted (due to payment from the insurance company) and the amount the Medical Assistance Program will pay. It was a reimbursement form to the Commission. The Kentucky Medical Assistance Program was our state Medicaid program for low-income families. Each state designed its own Medicaid program within federal guidelines. It was administered by the Health Services Cabinet through the Department for Medicaid Services (DMS). DMS worked in conjunction with the Department for Social Insurance to determine Medicaid or medical assistance eligibility.	Series contains: recipient name; medical assistance identification number; was patient in an accident; date of birth on recipient; prior authorization required?; name and address of insurance company and policy numbers (if applicable); category of service; was patient referred?; screening exam; diagnosis; diagnosis code; date of service; procedure description; procedure charge; total charge; professional rendering service; provider name; invoice date; provider number; name and address of hospital (if applicable); clinic number; invoice number	Agency: 5 Destroy after audit	Records Center:	Archives Center:
03203	Medical Assistance Statement - Dental Closed Date: 6/13/2008	Closed series. This series documented the cost of services provided by dentists, the amounts that would be deducted (because of payment from the insurance company), and the amount the Medical Assistance Program would pay. It was a reimbursement to the Commission. The physician had already been paid. The Kentucky Medical Assistance Program was our state Medicaid program for low-income people. Each state designed its own Medicaid program within federal guidelines. It was administered by the Health Services Cabinet through the Department for Medicaid Services (DMS). DMS worked in conjunction with the Department for Social Insurance to determine Medicaid or medical assistance eligibility. Dental services includes X-rays, fillings, simple extractions and emergency treatment for pain, infection and hemorrhage. Preventive dental care was stressed for children under age 21.	Series contains: recipient name; medical assistance identification number; name and address of health insurance company (if applicable); prior authorization number; universal tooth identification; date of service; procedure description; procedure code; units of service; place of service; tooth number; charges; provider certification and signature; provider name and address; provider number; invoice date; name and address of inpatient facility	Agency: 5 Destroy after audit	Records Center:	Archives Center:

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03243	Patient Encounter Forms Closed Date: 6/13/2008 (C) KRS 200.490	Closed series. This series documented the most up-to-date medical and personal data per child in the clinics. It provided information for federal, state and local statistics. The forms were filled out by the stenographer after the medical records had been returned from the clinic. It was completed after an initial visit to the clinic, whether the child was accepted into the Handicapped Children's program or not. The statistical information was important. All of the districts send the series to Frankfort. The office in Louisville gets the PEF Computer Printout - Quarterly Report (M0029). It provided annual information such as county district, the types of patients seen, and surgery codes. The information was provided in the clinic with the signs-in process. The client gave his name, county, and if this was an initial visit or a follow-up visit. From this sheet, the Patient Encounter Forms were done.	Series contains: Personal medical information; social security number; address; parent's name; family income; number of family members; date of birth; sex; race; date of visit; type of service provided; provider's number; diagnosis code; place of service; service code; if new patient; financially responsible parent	Agency: 1 Destroy	Records Center:	Archives Center:
03244	Patient Encounter Forms - Hemophilia Closed Date: 6/13/2008 (C) KRS 200.490	Closed series. This series documented the most up-to-date medical and personal data per person in the clinic. The Hemophilia Form was separate from the Patient Encounter Form (03243) due to the nature of their condition, and because this program continued for clients over the age of 21. It provided information for federal, state, and local statistics. The forms were completed by the stenographer after the medical records had been returned from the clinic. The districts sent the series to Louisville, not to Frankfort. A Quarterly Activity Report (M0029) was completed. The information was gathered in the clinic as a client signs in. The client gave his name, county and whether it was an initial visit or a follow-up visit. From this sheet, the series was completed.	Series contains: personal medical information; social security number; address; parent's name (if applicable); family income; number of family members; date of birth; sex; race; date of visit; type of service provided; provider's number; diagnosis code; place of service; service code; if new patient; person with financial responsibility	Agency: 1 Destroy	Records Center:	Archives Center:

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03241	Photographs	This series documents a photographic representation of accumulated events, activities and exhibits that have taken place in the past. Many represent public relations or promotional efforts. Some of these are pictures of patients before and after surgery, and date back to the 1920's. More recent photographs of events that include patients are only utilized with consent. The same disposition will apply to the negatives as with the photographs. There may also be photographs within the Client's Medical Record (Series 03246). These photographs are medically related and are only used by clinical staff. The photographs within the medical record are destroyed based on the retention schedule of the Client's Medical Record (Series 03246) or, if requested, released to the family or physician of care for continuity of care when the patient ages out of the Commission program.	Series contains: Photographs and digital pictures	Agency: I	Records Center:	Archives Center: Destroy upon approval of the State Archivist

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Commission for Children with Special Health Care Needs
Clinical Services
Hemophilia Program

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03256	Human Immuno Deficiency Virus Test Results (C) KRS 200.490 (V)	This series documents the positive or negative test results of patients who have taken the Human Immuno Deficiency Virus (HIV) Test. The test results make the treatment team at the Commission and the patient aware of the possibility of an AIDS virus or infection. It identifies by patient number whether or not a blood test has been identified positively or negatively for AIDS (presence of the HIV virus). The results are not filed in the Patient Medical Record for Hemophilia (03255). The intention is to protect the identity of a patient who has tested positively. The hemophilia nurse coordinator has a confidential list that matches a name with a identification number. The Program has contracts with the laboratories that do blood work. It may take a week or less to get the test results. Patients who have negative results will be tested and re-tested at various intervals, in case the virus is contracted at a later date or is slow to show positive activity. Should a test result be positive, the social worker makes a contact with the family. Unless some circumstance absolutely prohibits, a face to face contact is made to convey the news of the positive test result. The Program provides pre and post counseling for patients and families. Initially, an Elisa test is done. If a test result is positive, a western blot test is also done. These are two of the blood tests done to locate the virus.	Series contains: patient identification number; doctor's name; date of test; age of patient; sex; elisa test results; western blot test results; test code; requisition number	Agency: P	Records Center:	Archives Center:
				Retain in agency.		

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Clinical Services

Medical Records

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03248	Total Practice Management System - (TPMS 1.03) (Electronic) Closed Date: 6/13/2008 (C) KRS 200.490	Closed series. This series documented the summary of a Client's Medical Record (03246). There was not enough space to include everything one might find in the original medical record. It included the diagnosis of a patient, medication (if applicable), therapy, treatments, doctor recommendations, frequency of clinic visits and appointments, and brief medical history. The information was input by the medical transcriptionist, daily. The patient identification number was assigned by the Administrative Services - Reimbursement section. A back-up of files was completed at the end of each day, and a security copy was forwarded to the Administrative Services building. The names of clients were not processed in the system until they were accepted into the Commission's program for handicapped children. The verification would come from Reimbursement. The hardware and software was Burroughs, which was purchased from Unisys. The series was backed up once or twice per day and kept 1) on-site, 2) in a safe, 3) in the Administrative Building. Currently, no purging had been done.	Series contains: patient profile; patient diagnosis detail report; patient medication detail report; diagnosis summary report; medication summary report; diagnosis/medication cross-reference; diagnosis/procedure cross-reference; allergy list; medication list; medication history statistics report; procedure history statistics report; patient encounter report	Agency: I	Records Center: Update as changes occur. Daily backup procedures apply. Destroy purged information after five years	Archives Center:
03249	Doctor's Office Visits File Closed Date: 6/13/2008 (C) KRS 200.490	Closed series. This series documented progress notes written by a physician when a client was attended to in his office rather than the clinic (at the Commission). The notes were then added to the Client's Medical Record (03246). The series was kept separately even after having been added to the medical record. It was retained 1) for the doctor's signature (should a question arise about what was said, done, recommended or what was not said, done, or recommended), and 2) in case a typographical error had been made. It verified the doctor's orders. The series was not directly input into the Total Practice Management System (TPMS 1.03) (03248).	Series contains: name of patient; address; date of visit; summary of treatment; discussed recommendations for treatment and/or follow-up visits	Agency: 2 Destroy	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Clinical Services

Psychology

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03257	Patient Psychology Records Closed Date: 6/13/2008 (C) KRS 200.490	Closed series. This series documented the psychological state, past and present, of the patient. It recorded reports, tests, evaluations and notes that the psychologist used, and maintained in his work with patients. The psychologist did psychological evaluations on the individuals. It came from a child's medical history (all he was able to gather) and tests (personality, intelligence, developmental, vocabulary, spelling, achievement, neuropsychological). The tests were scored, evaluated and summarized. He obtained other clinical records (clinics, psychiatric facilities, hospitals, for the file. The psychologist provided for all other Commission medical information and reports, such as audiograms, medical information cards, diagnosis cards, and speech/language evaluations. He does psychoeducational evaluations, and receives reports from the appropriate school systems. Any other therapy summaries and evaluations from previous therapies were also included.	Series contains: patient name; address; date of birth; county home; parent's name; gender; race; marital status of parents; siblings; home phone; medical history; tests and test scores; clinic records; Commission medical information; evaluations and summaries; psychoeducation results and reports from client's school system; notes; drawings	Agency: 2 Destroy	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Commission for Children with Special Health Care Needs
Clinical Services
Speech and Hearing Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03252	Hearing Conservation Program File Closed Date: 12/31/1999	This series documents the hearing results of students being retested after an initial test has been done by the school system, health department, or trained volunteer. A referral letter is sent to parents by the school system requesting a follow-up evaluation or screening. Physicians or audiologist may retest, if necessary, if the child has failed the screening. If medical aid is desired, the parents make an application to the Handicapped Children Program, or pursue private means. The series maintains the names and results of the retesting services that are provided for the school systems. The students who are in need of further evaluation or medical intervention are sent letters by the schools.	Series contains: name of student; school attending; date retested; results of the hearing retest and tympanometry screening; if student was referred for further intervention; name of tester; referral letter (E-8)	Agency: 2 Destroy	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Disabled Children's Program

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03195	Client's Chart File Closed Date: 6/13/2008 (C) KRS 200.490	Closed series. This series documented the system for delivery of services for children with chronic illnesses and handicapping conditions in the Disabled Children's Program. The children require continuous care over long periods, some from birth, some are discovered later. The design of the program required planning and care for the total needs of the child. Educational programming had be considered along with treatment of physical and/or mental disabilities. A major emphasis of the program was to improve the child's ability to benefit from subsequent education or training, or otherwise improve his opportunities for self-sufficiency or self-support as an adult. Frequently, these services are provided by a variety of agencies. The result is a services delivery system which is continuous, comprehensive, coordinated, and concerned with the whole child. The individual services plan was the essence of what made up the chart, measuring a child's progress. The eligibility for children in the program was up to seven years of age or when they enter school. Although, technically, children are eligible up to 16 years of age, the Commission's budget limitations made it necessary to limit services to children under seven. The clients over age seven who have not had school placement are eligible if funds are available. The individual services plan is the emphasis of each client's rehabilitation program. The plan functions to organize and coordinated the goal-oriented care of each child with a handicapping condition. It is based on the interdisciplinary evaluation of the child's specific medical, education, developmental, social and rehabilitative needs. The plans were amended semiannually. Exceptions to this may be due to hospitalization. Necessary medications were prescribed by a physician. Objectives were to have a child ready for public school by age seven if at all possible.	Series may contain: authorization for services/billing form; name of district office; refusal of service; individual service plan forms - include name of child, address, date of birth, Medicaid eligible, other payment sources, diagnosis, case history, location, service plans, evaluations of medical, educational, social, developmental, dates, strength, limitations, needs, goals and long-term objectives, activities, provider, beginning date, frequency, duration, achievement date, estimated cost by item or service, comments, signature of case manager, responsible agency, address, review dates, parent/guardian signature, objectives, requested equipment/service, ordered by, billing name and address, cost, psycho-social evaluation includes background information, current life situation, previous treatment history, recommendations, miscellaneous patient expense request; eligibility forms	Agency: 5 Destroy after audit	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Division of Administrative Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
05762	Clinic Service Slip (C) KRS 205.175; KRS 61.878 (1) (a) and HIPPA	The Clinic Service Slip is used to document services rendered in clinic and/or by a service provider. This information is gathered in the clinic as a patient signs in and sees different providers (physician, speech therapist, audiologist, clinic nurse, etc). A Clinic Service Slip is completed for each patient attending clinic. The information is entered into Computer Utilization Project (" CUP") so that the Commission for Children with Special Health Care Needs billing agency may access the appropriate information and send out bills. The Clinic Service Slips must be maintained until the physician's dictation has been transcribed and signed.	Series may contain: Patient's name; date of birth; height; weight; information changes (phone, address, insurance); party accompanying the patient; date of visit; Current Procedural Terminology (" CPT") codes for visit level, service, and procedures; International Classification of Diseases, Ninth Revision, Clinical Modification (" ICD-9-CM") diagnosis codes; physician's signature; billing information; pay category; balance due; check number; collected; and receipt number.	Agency: 4 Destroy after audit	Records Center:	Archives Center:

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03246	Client's Medical Record (C) KRS 200.490 and HIPAA (V)	This series documents the information collected during encounters with individuals who become patients of the Commission for Children with Special Health Care Needs. The Medical Record contains sufficient information to clearly identify the client, supporting documentation for diagnosis and justify treatment, and to record the results accurately. The information records clinic visits, physician office visits, lab reports, speech evaluations, audiological reports, psychologists' reports, occupational and physical therapy evaluations, discharge summaries, consent for treatment, doctors' orders, medical summaries, official correspondence, release of information forms.	Series may contain: 1) Identifying information - name, address, phone number, date of birth, social security number, parents or guardian names; 2) Medical information - clinic notes (from the Commission or other clinics), office visits, lab reports, hospital visits, diagnosis, treatment, therapy recommendations, progress reports; 3) Social information - client's family, adopted or not, copy of birth certificate, custody papers (in the case of a divorce), divorce papers, name changes, declarations of the court, social worker's notes; 4) Financial information, family income, who's responsible for payments, wage verification, tax forms, authorization for service, correspondence, acceptance into program; HIPAA related forms	Agency: I Destroy seven (7) years after the child reaches the age of majority (21), and audit	Records Center:	Archives Center:
03247	Kardex File of Patients (C) KRS 200.490; KRS 68.878 (1)(a) (V)	This series documents and verifies the application, acceptance, or rejection into the Commission for Children with Special Health Care Needs. It identifies the name of the program that the client will participate in (i.e., speech and hearing, physical therapy, occupational therapy, hemophilia, or specialized clinic) and the attending physician. This series also provides prompt reference information. If there is not a medical record on file, this record would be the next place for reference to determine if the child had been admitted in the Commission for Children with Special Health Care Needs program. The series provides long-term reference for research information and it documents disability status in adulthood as the original medical record (Series 03246) is not a permanent record.	Series contains: This series may contain: client's name; address; telephone number; date-of-birth; date of application; type of services; attending physician; status (accepted, rejected, discharged, expired)	Agency: P Retain in agency	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Commission for Children with Special Health Care Needs
Division of Administrative Services
Intake Branch

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03245	Eligibility Acceptance/Rejection File (C) KRS 200.490	This series documents the children/young adults who have been accepted and rejected for service by a Commission for Children with Special Health Care Needs Eligibility Committee. After an initial medical evaluation, various aspects of an applicant's family situation are reviewed to determine if the applicant meets the eligibility criteria established for acceptance into Commission for Children with Special Care Needs' program. These aspects include the number of family members, family income, insurance coverage, and medical diagnosis of the applicant. When an applicant is accepted into the program, a pay category is assigned which determines if the family will be responsible for any, partial, or all of the medical bills. Eligibility determination is communicated by letter and the applications are kept in each district.	Series contains: worksheets; client's name(s); date they were accepted/rejected; county district; (if rejected) reason for rejection; eligibility Committee's application summary; totals of children accepted/rejected	Agency: 1 Destroy	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Division of Health and Development

Hemophilia Program

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
				Agency:	Records Center:	Archives Center:
03255	Patient Medical Record for Hemophilia (C) KRS 200.490; KRS 61.878 (1)(a); HIPAA (V)	This series documents the information gathered during encounters with those who become patients or clients in the Commission for Children with Special Health Care Needs Hemophilia Program pursuant to KRS 200.550. The Hemophilia Program includes adults and children due to the nature of the condition and is not corrected by the age of twenty one (21). The record, to be complete, must contain sufficient information to clearly identify the client, documentation to support the diagnosis, justify the treatment and record the results accurately. This information is recorded as it progresses with clinic visits, physician office visits, social worker notes, psychologists reports, doctor's order, medical summaries, correspondence, bleeding logs, home visits, joint measurements by physical therapists and lab reports. (The Human Immuno Deficiency Virus Test Results are not included in this series but are covered in the series number 03256.) If hospitalization is required for tests and/or surgery, the proper authorizations and documentation of those visits are included in this series.	Series may contain: Identifying information - Patient name, address, phone number, date of birth, social security number, parents (if applicable); medical information - clinic notes, doctor's office visits, (some) lab reports, hospital visits, diagnosis, treatment, progress reports, bleeding logs, joint measurements; social information - patient family information, home visits reports, type of work; financial information - family income, wage verification, tax information, insurance information and verification, authorization for service; authorization for hospitalization admission/surgery, consent forms, discharge notes; correspondence	P	P	

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Commission for Children with Special Health Care Needs
Division of Quality Outcomes Management
Early Hearing Detection and Intervention Branc

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
				Agency:	Records Center:	Archives Center:
03251	Early Hearing Detection and Intervention Program - (Electronic) (V) (C) KRS 200.490,KRS 68.878 (1)(a) and HIPAA	This series documents infants who have a risk of hearing impairment. Data is compiled by the Commission for Children with Special Health Care Needs by receiving Hearing Screen Reports from birthing hospitals in Kentucky that identify infants that refer on the physiologic hearing screening prior to discharge, not tested, or have a risk indicator for late onset or progressive hearing loss. The data is transferred electronically from the birthing hospital into the Computer Utilization Project (CUP). Some hospitals provide a paper copy to the Commission for Children with Special Health Care Needs which is manually entered into CUP. The data is used to develop statistical information, compile reports, disseminate information to families, provide follow-up to families, and for surveillance and tracking. Monthly, semi-annual and annual reports of aggregate data are compiled and may be sent or shared with the following: Early Childhood Appointing Authority; Kentucky Commission on Deaf or Hard of Hearing; Federal grant statistical data; Directors of Speech and Hearing Programs in State Health and Welfare Agencies.	Series contains: This series may contain: Name of child; date-of-birth; sex; birth hospital; county; physician; parents' name and address; hearing screen report results; risk factor checklist; scheduled appointments and if seen; the results, correspondence between staff and families.	3		Destroy paper copies and discharge inactive information in the Computer Utilization Project

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Division of Quality Outcomes Management

Occupational Therapist

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
				Agency:	Records Center:	Archives Center:
03261	Patient Progress File - Occupational Therapy (C) KRS 200.490; KRS 68.878 (1) (a); HIPAA	This series documents occupational therapy progress, dates of therapy, when it begins, length of therapy and frequency for clients of the Commission for Children with Special Health Care Needs. Also included in this series are a brief medical history, diagnoses, neuromuscular status, skill level, and plan of treatment. The plan of treatment consists of prognosis, amount of time seen per visit, and times to be seen per week or month. Length of therapy varies and is determined by progress of patient, a one time visit for splint fabrication or if the patient has had surgery. Should a patient plateau in therapy for an extended period, therapy is discontinued until another physician referral is made due to parental request or change in patient's functional status. The Commission for Children with Special Health Care Needs requires a written prescription for occupational therapy with the physician's signature. Each patient visit is also documented in the Computer Utilization Project (CUP). The originals records are placed in Client's Medical Record (03246) by discharge.	Series contains: name; Occupational Therapy Evaluations; Treatment Plans, Therapy Progress Notes diagnosis; patient's name; parents; address; date of birth; referring physician; date of referral; date of visits	I		Destroy five years after last date of service

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Division of Quality Outcomes Management

Physical Therapist

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
				Agency:	Records Center:	Archives Center:
03258	Patient Progress File - Physical Therapy (C) KRS 200.490; KRS 68.878 (1) (a); HIPAA	This series documents the physical therapy history of client's for Commission for Children with Special Health Care Needs, including a physical therapy evaluation. The physical therapy history consists of each physical therapy visit, the beginning date, progress, dates of therapy, length of therapy and frequency. The physical therapy evaluation consists of a patient history, diagnoses, neuromuscular status, all pertinent tests, assessments, goals and plan of treatment. Length of therapy is individualized for each patient and determined by the doctor's orders and goals to be achieved. A physician referral is required prior to every evaluation including patients who were previously seen by physical therapy and discharged. The prescription can be written for evaluation and/or treatment or specify a treatment area to be addressed. Copies may be kept at the treatment center to document patient's progress or for insurance purposes. Each physical therapy visit is documented in the Computer Utilization Project (CUP).	Series contains: Patient's name; DOB; parents; address; authorization for physical therapy; diagnosis; referring physician; date of referral; records of therapy at each visit; changes in progress	I		Destroy five years after last date of service

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Commission for Children with Special Health Care Needs
Division of Quality Outcomes Management
Physical Therapy

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
				Agency:	Records Center:	Archives Center:
03260	Wheelchair Prescription File	This series documents the necessary information that a vendor needs to bid on a wheelchair. In the event that the child is not covered by insurance or the insurance does not cover the cost of the wheelchair or only a portion of the cost, a wheelchair may be put out on bid. The child will need to have the wheelchair ordered by their physician in the clinic and must be seen by a physical therapist for an evaluation. A physical therapist will need to complete the wheelchair evaluation form. The form describes the child's posture, medical condition, type of chair required, modifications required on the chair, and any other pertinent information. Copies of the form are attached to each bid and sent out to all the vendors on the Commission's bid list, which consists of vendors in that particular geographic area from which the chair is being ordered. Bids are sent out through the Provider's Relations Branch at the Commission. Once the bid is awarded, that vendor must meet with patient, family, and therapist to re-measure the patient and at that time the wheelchair is ordered. Payment is made when the wheelchair has been delivered to the patient and is determined to fit appropriately.	Series contains: Request for Equipment Form; client's name; date; age; address; diagnosis; name of referral and plan treatment; physician; motor control (head control, trunk and hip control, leg control, functional activities); environment (means of transportation, home, classroom, school, child has (not) ability to lift or maneuver wheelchair); child's measurements; accessories and attachments (head support, lateral trunk supports, back modifications, seat modifications, arm supports, leg rests, foot rests, miscellaneous, basic chair needs); specific brand of chair; physical therapist's signature and phone number.	2 Destroy		

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Commission for Children with Special Health Care Needs
Division of Quality Outcomes Management
Speech and Hearing Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
				Agency:	Records Center:	Archives Center:
03254	Speech and Hearing Reports - Non-Medical (C) KRS 200.490 and HIPAA	This series documents original speech-language evaluation reports, treatment plan reports and audiological evaluation reports filed in the patient record. The summary notes regarding these reports are placed in the Computer Utilization Project (also known as "CUP"). Speech therapy progress notes are also documented in CUP after each therapy visit and the paper copies are kept in the patient file for planning and treatment purposes. All Speech and Hearing patient records are kept in the Treatment Center as these patients are not enrolled in the Commission for Children with Special Health Care Needs medical clinics.	Series contains: This series may contain: Speech, language and voice evaluation; speech therapy logs; hearing evaluations; intake/eligibility documentation (application, financial form, insurance verification, authorization for treatment, correspondence, acceptance or non-acceptance into the program), HIPAA privacy notice	I	Destroy seven (7) years after child reaches the age of majority (21).	

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Executive Office

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
03240	Grant Project Proposals and Guidelines (V)	This series documents need assessments for program expansion and supplemental funding assistance within the Commission for Children with Special Health Needs (hereinafter "Commission"). The proposals are used as guidelines and reference for future proposals, and planning, writing, and reporting purposes. Some of the grants are to aid in the outreach and publicizing of Commission programs. Grants provide for program development, such as hearing conservation, client and family counseling, therapy, medical services, wheelchairs, and infant stimulation programs. The needs for supplemental funding are researched before it is determined which areas will use the financial resources. Proposals are made by the Director of Administrative Services Branch and the Director and/or Executive Director receive ideas from other program directors. Copies of the final form proposals are circulated to the Medical Director, Executive Director, and each Division Director. In making requests for funding, management may or may not grant it or will possibly modify the grant request. Stipulations may be attached, or a team of administrators may be dispatched to do a "cooperative" report before final decisions are made.	Series may contain: Special project summaries; statistical data, as appropriate; program planning; supplemental funding requested	Agency: 10 Destroy after audit	Records Center:	Archives Center:

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Personnel Training and Outreach

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
				Agency:	Records Center:	Archives Center:
03242	Licensed Professionals Continuing Education Records (C) KRS 61.878 (1)(a) - Personal info and SS number (V)	This series documents the continuing education records the Commission for Children with Special Health Care Needs sponsorship of presentations that qualify for licensed professionals' continuing education contact hours. Those receiving approved contact hours may include nurses, social workers, speech language pathologists, audiologists, pharmacists, pharmacy technicians, x-ray technicians, early childhood workers and other interested persons. Certificates are provided to participants as proof of their attendance, Each participant is responsible for individual records to present to his/her professional board when audited. The Commission for Children with Special Health Care Needs maintains status as an approved provider of nursing contact hours and follows 201 KAR 20:220 (Nursing Continuing Education Provider Approval). Beginning January 2007, each approval period will last for a five (5) year period. Approval from other professional boards is obtained by submitting an application for each presentation to each professional board for their approval. If approved, the approval letter is placed in the file for the individual presentation and the number of contact hours approved by the particular board is listed on the certificate of attendance.	Series may contain: Evaluation of - content, speakers, facility for conferences; copy of handouts given at presentations (if applicable); copies of communications to speakers and other agencies involved in producing the conference; sample certificates; programs and master content outline/objectives; participant roster of all Registered Nurses, Licensed Practical Nurses, and others attending conferences with social security numbers and Professional License Number (Kentucky) based on sign-in sheets containing names, addresses, agencies and license/certification numbers and Social Security numbers	12	Destroy after audit	

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services

Commission for Children with Special Health Care Needs

Quality Outcomes Management Division

Therapeutic Services

Series	Records Title and Description	Function and Use	Contents	Retention Disposition Instruction		
				Agency:	Records Center:	Archives Center:
03253	Speech and Hearing Reports - Medical (C) KRS 200.490, KRS 68.878 (1) (a)	This series documents records on patients who receive speech therapy. The series contains sufficient information to clearly identify the patient, to support the diagnosis, and justify treatment based on speech-language evaluation reports, audiological evaluation reports, and treatment plans. Original speech-language evaluation reports, treatment plan reports, and audiological evaluation reports are filed in the Client's Medical File (series 03246) with summary notes regarding these reports placed in the Computer Utilization Program (CUP). Speech therapy progress notes are documented in CUP after each therapy visit and paper copies of these notes are kept within this series for planning and treatment purposes.	Series contains: speech; language; voice evaluations; speech therapy logs; hearing evaluations; hearing aid evaluations; hearing aid check reports	I		Destroy five (5) years after last date of service

Electronic System With Included Records Series

Cabinet Name: Cabinet for Health and Family Services

Department Name: **Commission for Children With Special Health Care Needs**

System Title: **Computer Utilization Project** ***Alternate Title:*** CUP

System Description: A web-based data entry system designed to be accessed by CCSHCN staff across the state to allow continuity of care for patients. NOTE: The following series are exclusively contained in CUP - 05770 and 03251. CUP contains a portion of data making up the following series - 03204, 03246, 03253, 03254, 03255, 03258 and 03261. These series have information that may be found in CUP such as demographic data but the hardcopy record needs to be retained - 03247 and 05762. Series 03247 and 03255 are the only permanent records. They are preserved in a paper format in the agency.

System Contents: Patient/contact finder, clinic finder, International Classification of Diseases, Ninth edition, Clinical Modification (ICD-9-CM) look up, patient demographics, notes, social history, insurance, services, appointments, transition milestones, hemophillia data, early hearing and detection results, diagnoses, financial, hearing tests, dental information, medications, images, contact and contracting information for physicians and providers, ICD-9 coding, clinic dates and locations, appointments, medical alerts, insurance infor., social data. It also includes a message and tasking system.

Series #:	*Series Title:*	*Disposition Instructions:*	*Total Retention:*
03204	Patients Statement of Account	Destroy after audit	5
03246	Client's Medical Record	Destroy seven (7) years after the child reaches the age of majority (21), and audit	I
03247	Kardex File of Patients	Retain in agency	P
03251	Early Hearing Detection and Intervention Program	Destroy paper copies and discharge inactive information in the Computer Utilization Project	3
03253	Speech and Hearing Reports - Medical	Destroy five (5) years after last date of service	I
03254	Speech and Hearing Reports - Non-Medical	Destroy seven (7) years after child reaches the age of majority (21).	I

Electronic System With Included Records Series

System Title: **Computer Utilization Project** ***Alternate Title:*** CUP

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System Contents: Patient/contact finder, clinic finder, International Classification of Diseases, Ninth edition, Clinical Modification (ICD-9-CM) look up, patient demographics, notes, social history, insurance, services, appointments, transition milestones, hemophillia data, early hearing and detection results, diagnoses, financial, hearing tests, dental information, medications, images, contact and contracting information for physicians and providers, ICD-9 coding, clinic dates and locations, appointments, medical alerts, insurance infor., social data. It also includes a message and tasking system.

Series #:	*Series Title:*	*Disposition Instructions:*	*Total Retention:*
03255	Patient Medical Record for Hemophilia	Retain in agency	P
03258	Patient Progress File - Physical Therapy	Destroy five years after last date of service	I
03261	Patient Progress File - Occupational Therapy	Destroy five years after last date of service	I
05762	Clinic Service Slip	Destroy after audit	4
05770	Computer Utilization Project	Destroy when no longer useful	I